STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/30/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERITUS AT FORT WAYNE	4730 E STATE BLVD FORT WAYNE, IN46815

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R0000	This visit was for the investigation of Complaint Number IN00094798. Complaint Number IN00094798-Unsubstantiated due to lack of evidence. Unrelated deficiency is cited. Survey dates: August 29, 30, 2011 Facility number: 003273 Provider number: 003273 AIM number: N/A Survey team: Ann Armey, RN Census Bed Type: Residential: 63 Total: 63 Census payor type: Other: 63 Total: 63 Sample: 3 This state finding is cited in accordance with 410 IAC 16.2-5. Quality review 9/01/11 by Suzanne	R0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Williams, RN			
R0246	(6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on interview and record review, the facility failed to assure a QMA received and documented authorization to administer PRN medications. This deficiency affected 2 of 2 residents, who received PRN medications, in a sample of 3. (Resident #B and #C) Findings include: 1. The clinical record of resident #C was reviewed on 8/29/11 at 11:00 a.m. and indicated the resident was admitted to the facility on 6/4/11, with a diagnosis which included but was not limited to, Alzheimer's Disease. The August 2011 MAR	R0246	1. The MARs and charts were reviewed for Residents #B and #C, no negative outcomes were noted.2. MARs and charts of the residents that QMAs are responsible for were reviewed from 8/30/2011 through 9/8/2011. Only one PRN medication had been given, permission was asked and granted, proper documentation was noted.3. QMAs received a one on one in-service reviewing their scope of practice. An in-service for all licensed nurses and QMAs is scheduled for September 15, 2011 to again review the QMAs scope of practice for giving PRN medications. During weekly med cart audit we will be reviewing the MARs and Charts of 5 random residents to check PRN medications administration and documentation, the audits will be conducted by the Resident Care Director or Designee.4. The weekly med cart audits will be reviewed by the Executive Director and/or designee weekly	09/16/2011

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	(Medication Administration Record) indicated Resident #C had physician orders to received Ativan 0.5 mg, every six hours as needed for anxiety or agitation and Tylenol 1000 mg, every four hours as needed for mild pain. The Nurse's Medication Notes on the back of the MAR indicated the resident had received PRN medications as follows: On 8/2/11 at 3:00 p.m., Ativan 0.5 mg for increased agitation, On 8/3/11 at 3:00 p.m., Ativan 0.5 mg for increased agitation, On 8/3/11 at 3:00 p.m., Tylenol 1000 mg for a headache, and On 8/5/11 at 5:00 p.m., Ativan 0.5 mg for increased agitation. On 8/29/11 at 11:20 a.m., the RCD (Resident Care Director) was interviewed. She indicated the PRN Ativan and Tylenol had been administered by QMA (Qualified Medication Aide) #1. The RCD indicated a licensed nurse was in the facility twenty-four hours each day, and the		times four weeks and then and also at the monthly CQI meetings.Regional Director of Quality Service to review med cart audits during site visits and during annual comprehensive process review. 5. The systemic changes will be completed by September 16, 2011.	

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	QMAs should obtain and document that the licensed nurse authorized the use of the PRN medication. The clinical record was reviewed with the RCD and there was no documentation indicating the licensed nurse had been consulted or authorization had been obtained each time the PRN Ativan and Tylenol were administered to Resident #C by QMA #1. 2. The clinical record of Resident #B was reviewed on 8/29/11 at 2:15 p.m. and indicated the resident was admitted to the facility on 6/19/07 with a diagnosis which included but was not limited to, dementia. The August 2011 MAR (Medication Administration Record) indicated Resident #B had a physician's order to give Ativan 0.5 mg, every six hours as needed for anxiety or agitation. The Nurses Medication Note indicated the Ativan had been given by QMA #1 on 8/19/11 at 7:30 p.m. There was no documentation the			

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	nurse had been consulted or authorization had been obtained when the PRN Ativan was given to Resident #B. On 8/29/11 at 3:25 p.m., QMA #1 was interviewed. She indicated she thought she had checked with the nurse before giving the PRN medications to Residents #C and #B and she should have documented this. QMA #1 indicated she was unsure what happened because it was very busy on the unit. She indicated she attended an inservice on 8/29/11 and giving PRN medications was not within her scope of practice. On 8/29/11 at 4:30 p.m., the RCD was interviewed. She indicated they had no specific policy regarding QMAs giving PRN medications, and the facility followed Indiana's QMA regulations and guidelines. The QMA regulations, including 412 IAC 2-1-9 Scope of Practice, provided by the RCD, were			

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	reviewed, on 8/30/11 at 9:30 a.m., and indicated the following: "...(11) Administer previously ordered pro re nata (PRN) medications only if authorization is obtained from the facility's licensed nurse on duty or on call. If authorization is obtained, the QMA must do the following: (A) Document in the resident record symptoms indicating the need for the medication and the time the symptoms occurred. (B) Document in the resident record that the facility's licensed nurse was contacted, symptoms were described, and permission was granted to administer the medication, including the time of contact. (C) Obtain permission to administer the medication each time the symptoms occur in the resident. (D) Ensure that the resident's record is cosigned by the licensed nurse who gave permission by the end of the nurse's shift or, if the nurse was on call, by the end of the nurse's next tour of duty..."			

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	On 8/30/11 at 1:30 p.m., the Executive Director was interviewed. The Executive Director indicated they had checked the records and only one QMA was involved and in those cases; the QMA and nurses were not documenting authorization was given.			